172

(1)

Supreme Court, U.S.
FILED
OCT 12 2010
OFFICE OF THE CLERK

No. 10-498

In The
Supreme Court of the United States

THERESA NOREN,

Petitioner,

v.

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY, LINCOLN NATIONAL CORPORATION, and CARTOYS, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES
COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

Steven P. Krafchick
Counsel of Record
Carla Tachau Lawrence
Pamela S. Van Swearingen
Attorneys for Petitioner
Krafchick Law Firm
100 West Harrison, South Tower, Ste. 300
Seattle, WA 98119
(206) 374-7372

No.

In The
Supreme Court of the United States

THERESA NOREN,

Petitioner,

v.

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY, LINCOLN NATIONAL CORPORATION, and CARTOYS, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES
COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

Steven P. Krafchick
Counsel of Record
Carla Tachau Lawrence
Pamela S. Van Swearingen
Attorneys for Petitioner
Krafchick Law Firm
100 West Harrison, South Tower, Ste. 300
Seattle, WA 98119
(206) 374-7372

QUESTION PRESENTED

Does an insurer's failure to comply with ERISA[1]-required notice in the Summary Plan Description of all procedures and time frames that are a prerequisite to judicial review, creating a conflict with the relevant plan provision(s), bar the insurer's non-statutory, non-jurisdictional defense that the claimant failed to exhaust administrative remedies?

---

[1] Employee Retirement Income Security Act.

LIST OF PARTIES

The parties to this action are listed in the caption: the Petitioner, Theresa Noren, was plaintiff and appellant in the courts below. Jefferson Pilot Financial Insurance Company, Lincoln National Corporation, and CarToys, Inc., were defendants and appellees.

TABLE OF CONTENTS

QUESTION PRESENTED i

LIST OF PARTIES ii

OPINION BELOW 1

STATEMENT OF JURISDICTION 2

STATUTES, REGULATIONS, COURT RULES INVOLVED 3

STATEMENT OF THE CASE 12

REASONS FOR ALLOWING THE WRIT 14

I. PRELIMINARY STATEMENT RE CONFLICTS 14

II. THE COURT SHOULD ACCEPT CERTIORARI TO HARMONIZE CIRCUIT CONFLICTS OVER THE EFFECT OF ERISA-REQUIRED NOTICE AND DISCREPANCIES BETWEEN THE PLAN AND SPD 15

A. Without ERISA-Required Notice, Insurers Cannot Assert Prudential Exhaustion 15

B. Conflicts Between SPD and Plan 22

III. THE NOREN DECISION CONFLICTS WITH THIS COURT'S HOLDING THAT NON-STATUTORY DEFENSES ARE NOT JURISDICTIONAL.....29

A. The Ninth Circuit Ignored, And This Court Should Settle, The Rule That Prudential Exhaustion Is A Non-Jurisdictional Affirmative Defense.....29

B. The Court Should Guide Lower Courts Regarding *Bowles'* Distinction Between A Jurisdictional Bar And A Non-statutory Affirmative Defense, So That Exceptions To Prudential Exhaustion Are Accurate And Consistent.....31

1. Exceptions To Prudential Exhaustion.....31

2. Deemed Exhausted Regulation...33

3. Futility.....37

4. The Burden Is On the Insurer, Not The Claimant, To Prove The Exhaustion Defense.....38

IV. THE *NOREN* DECISION CONFLICTS WITH THIS COURT'S HOLDING THAT ERISA IMPOSES ON INSURERS A HIGHER-THAN-MARKETPLACE FIDUCIARY DUTY TOWARD PLAN PARTICIPANTS.....39

V. CONCLUSION.....41

TABLE OF AUTHORITIES

Cases

Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955 (2006) 24

Ace Prop. & Cas. Ins. Co. v. Fed. Crop. Ins. Corp., 440 F.3d 992 (8th Cir. 2006 32

Aiken v. Policy Mgmt. Sys. Corp., 13 F.3d 138 (4th Cir. 1993) 27

Alday v. Container Corp. of America, 906 F.2d 660 (11th Cir. 1990) 23

Anderson v. Chrysler Corp., 99 F.3d 846 (7th Cir. 1996) 26

Arbaugh v. Y&H Corp., 546 U.S. 500 (2006) 29, 30

Arnold v. Arrow Transp. Co., 926 F.2d 782 (9th Cir. 1991) 24

Asgaard v. Pension Comm., 2006 U.S. Dist. LEXIS 74679 (W.D.Mich. 2006)..... 35

Atwood v. Newmont Gold Co., 45 F.3d 1317 (9th Cir. 1995 24

Banuelos v. Constr. Laborers' Trust Funds, 382 F.3d 897 (9th Cir. 2004) 24

Baptist Mem. Hosp. - Desoto, Inc. v. Crain Auto., Inc., 2010 U.S. App. LEXIS 17518 (5th Cir. Aug. 19, 2010) 34

Barboza v. Cal. Ass'n of Prof'l Firefighters, 2009 U.S. Dist. LEXIS 52848 (E.D.Cal. 2009) 36

Bastek v. Fed. Crop Ins. Corp., 145 F.3d 90 (2nd Cir. 1998) 32

Bergt v. Retirement Plan for Pilots Employed by Mark Air, Inc., 293 F.3d 1139 (9th Cir. 2002) 22, 23, 24

Blankenship v. Metropolitan Life Ins. Co., 686 F.Supp.2d 1227 (N.D.Alabama 2009)..... 27

Bowen v. City of New York, 476 U.S. 467, 106 S.Ct. 2022, 90 L.Ed. 2d 462 (1986) 32

Bowles v. Russell, 551 U.S. 205 (2007)...29, 30, 31, 40

Branch v. G. Bernd Co., 955 F.2d 1574 (11th Cir. 1992) 26

Brogan v. Hartford Life Ins. Co., 2009 U.S. Dist. LEXIS 85101 (S.D.Ohio 2009) 35

Burke v. Kodak Ret. Income Plan, 336 F.3d 103 (2d Cir. 2003) .....passim

Chailland v. Brown & Root, Inc., 45 F.3d 947 (5th Cir. 1995) 31

Chappel v. Laboratory Corp. of America, 232 F.3d 719 (9th Cir. 2000) 21

Chiles v. Ceridian, 95 F.3d 1505 (10th Cir. 1996) . 23, 27

Chuck v. Hewlett Packard Co., 455 F.3d 1026 (9th Cir. 2006) 21

Collins v. Am. Cast Iron Pipe Co., 105 F.3d 1368 (11th Cir. 1997) 26

Conkright v. Frommert, 130 S. Ct. 1640, 176 L. Ed. 2d 469 (2010) 40

Dawson Farms, LLC v. Farm Serv. Agency, 504 F.3d 592 (5th Cir. 2007) 32

Dishman v. UNUM Life Ins. Co. of Am., 269 F.3d 974 (9th Cir. 2001) 20, 32

Eastman Kodak Co. v. STWB, Inc., 452 F.3d 215 (2d Cir. 2006) 36, 37

Eberhart v. United States, 546 U.S. 12 (2005) 29

Edwards v. State Farm Mut. Auto. Ins. Co., 851 F.2d 134 (6th Cir. 1988) 23, 27

Fleming v. Kemper Nat'l Servs., 2004 U.S. Dist. LEXIS 28381 (N.D.Cal. 2004) 35

Govoni v. Bricklayers, Masons & Plasterers Int'l. Union of Am., Local No. 5 Pension Fund, 732 F.2d 250 (1st Cir. 1984) 27

Gridley v. Cleveland Pneumatic Co., 924 F.2d 1310 (3rd Cir. 1991) 26

Hansen v. Continental Ins. Co., 940 F.2d 971 (5th Cir. 1991) 23, 27

Harris County Hosp. Dist. v. Shalala, 863 F. Supp. 404 (S.D.Tex. 1994), *aff'd*, 64 F.3d 220 (5th Cir. 1995) 19

Healthcare Corp. Health Plan, 546 F.3d 620 (9th Cir. 2008) 33

Heidgerd v. Olin Corp., 906 F.2d 903 (2d Cir. 1990) 22

Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. Skinner Engine Co., 188 F.3d 130 (3d Cir. 1999) 23

Jacobs Eng'g Group Long Term Disability Ben. Plan, 896 F.2d 344 (9th Cir. 1990) 21

Jensen v. SIPCO, Inc., 38 F.3d 945 (8th Cir. 1994) 23

Karpiel v. Ogg, Cordes, Murpy, & Ignelzi, LLP, 297 Fed. Appx. 192 (3d Cir. 2008) 38

Kegel v. Brown & Williamson Tobacco Corp., 2009 U.S. Dist. LEXIS 88783 (D. Nev. 2009)..... 34

Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 129 S.Ct. 865 (2009) 23

Kontrick v. Ryan, 540 U.S. 443 (2004) 29

Koons v. Aventis Pharms., Inc., 367 F.3d 768 (8th Cir. 2004 25

LaMantia v. Voluntary Plan Administrators, Inc., 401 F.3d 1114 (9th Cir. 2005) 21

Linder v. BYK-Chemie USA, Inc., 313 F.Supp. 2d 88 (D.Conn. 2004)..... 35

McBride Cotton & Cattle Corp. v. Veneman, 290 F.3d 973 (9th Cir. 2002) 32

McKnight v. Southern Life & Health Ins. Co., 758 F.2d 1566 (11th Cir. 1985)..... 23

Mers v. Marriott Int'l Group Acc. Death and Dismemberment Plan, 144 F.3d 1014 (7th Cir. 1998) 25

Metro. Life Ins. Co. v. Price, 501 F.3d 271 (3d Cir. 2007) 30

Metropolitan Life Ins. Co. v. Glenn, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008) 28, 39, 40, 41

Metropolitan Life Insurance Co. v. Price, 501 F.3d 271 (3rd Cir. 2007) 32, 38

Miller v. Gammie, 335 F.3d 889 (9th Cir. 2003)..... 30

Noren v. Jefferson Pilot Fin. Ins. Co., 2010 U.S. App. LEXIS 9495 (9th Cir. Wash. May 10, 2010)..... 1

Northwest Tissue Ctr. v. Shalala, 1 F.3d 522 (7th Cir. 1993 32

Palmisano v. Allina Health Sys., Inc., 190 F.3d 881 (8th Cir. 1999) 27

Parlanti v. MGM Mirage, 2007 U.S. Dist. LEXIS 20003, at *14-15 (D. Nev. 2007)..... 38

Pease v. Hartford Life & Accident Ins. Co., 449 F.3d 435 (2d Cir. 2006)..... 31, 38

Ross v. Diversified Benefit Plans, Inc., 881 F.Supp. 331 (N.D. Ill. 1995)..... 19

Sierra Club v. United States Forest Serv., 535 F.Supp.2d 1268 (N.D.Ga. 2008) 32

Solien v. Raytheon Long Term Disability Plan # 590, 2008 U.S. Dist. LEXIS 43194 (D.Ariz. 2008) 21

Tindell v. Tree of Life, Inc., 672 F. Supp.2d 1300 (M.D. Fla. 2009) 36

Urso v. Prudential Ins. Co. of Am., 2004 U.S. Dist. LEXIS 23930, 2004 WL 3355265 (D.N.H. 2004).. 35

Vaught v. Healthcare Corp. Health Plan, 546 F.3d 620 (9th Cir. 2008) .....passim

White v. Jacobs Eng'g Group Long Term Disability Benefit Plan, 896 F.2d 344 (9th Cir. 1990..... 19, 21

Statutes

29 U.S.C. § 1001 1

29 U.S.C. §1022(a) 17

29 U.S.C. §1104 ..... 28, 39

29 U.S.C. § 1132(e)(1) 13

29 U.S.C. § 1132(f) 13

29 U.S.C. §1144(a) 26

28 U.S.C. §1254(1) 2

28 U.S.C. § 1291 13

28 U.S.C. § 1331 13

28 U.S.C. § 1331(1) 17

Regulations

Statutes and Regulations relies upon are cited or set forth at pages 3-11.

29 C.F.R. §2520.102-2(b) 18

29 C.F.R. § 2520.102-3(j)(2) 16, 17

29 C.F.R. § 2520.102-3(l) 16, 17, 18

29 C.F.R. § 2560.503-1 ..... 16, 17

29 C.F.R. §2560.503-1(a) 17

29 C.F.R. §2560.503-1(b) ..... *passim*

29 CFR 2560.503-1(b)(2) 16

29 C.F.R. §2560.503-1(c) 16

29 C.F.R. §2560.503-1(d) 16

29 C.F.R. §2560.503-1(e) 16

29 C.F.R. §2560.503-1(f) ..... *passim*

29 C.F.R. §2560.503-1(g) 17

29 C.F.R. §2560.503-1(h)(4) 17

29 C.F.R. §2560.503-1(j) 17

29 C.F.R. §2560.503-1(*l*) ..... *passim*

29 C.F.R. §2560.503-1(m) 10

APPENDIX INDEX

Order denying petition for rehearing en banc, filed June 29, 2010 ..... 1a

Memorandum of the United States Court of Appeals for the Ninth Circuit, filed May 10, 2010 ..... 2a

Hawkins, Circuit Judge, dissenting, filed May 10, 2010 ..... 6a

District Court's Order (granting Defendants' motion for summary judgment), filed March 2, 2009..... 7a

Title 29, United States Code, Sections 1104(a)(1), 1133(1)–(2), Title 29, Code of Federal Regulations, Sections 2520.102-3, 2560-503-1(a), (b)(1)-(3), (b)(1)(5), (c)(2), (f), (f)(3), (g)(1)(iv)-(v)(a), (h)(2)(iii)-(iv), (h)(4), (i)(5), (j)(2)-(3), (j)(5)(i), (l), (m)(4)-(5), (m)(8)(iv)..... 14a

Excerpts from Jefferson Pilot Summary Plan Description 25a

Excerpts from Jefferson Pilot Short Term Weekly Disability Policy..... 27a

Excerpts from Jefferson Pilot Long Term Disability Policy 28a

Excerpts of Krafchick Law Firm letter to Jefferson Pilot Financial dated November 15, 2005 ..... 30a

Excerpts of Jefferson Pilot Financial letter to Krafchick Law firm dated December 12, 2005 ..... 32a

Jefferson Pilot Financial adverse benefit decision letter dated November 3, 2006 ..... 34a

Excerpt from Krafchick Law Firm letter to Jefferson Pilot Financial dated November 6, 2006 ..... 39a

Appeal Worksheet..... 42a

OPINION BELOW

Unpublished opinion of Ninth Circuit Court of Appeals, No. 09-35242, Memorandum, *Noren v. Jefferson Pilot Fin. Ins. Co.*, 2010 U.S. App. LEXIS 9495 (9th Cir. Wash. May 10, 2010)(Goodwin and N.R. Smith, JJ., majority; Hawkins, J., dissenting)(Reprinted at Appendix 2a-5a; dissent at Appendix 6a). A majority of the Court of Appeals panel affirmed the District Court. (App. 7a-13a), *Noren v. Jefferson Pilot Fin. Ins. Co.*, 2009 U.S. Dist. LEXIS 16157 (unpublished)(W.D. Wash. Mar. 2, 2009), granting respondents' motion for summary judgment dismissing the case on jurisdictional grounds. The District Court denied judicial review of Noren's disability benefits claim, in an employee benefit plan governed by ERISA, 29 U.S.C. § 1001 *et seq.*, which was fully insured by Respondents.

STATEMENT OF JURISDICTION

(i) The District Court entered its Order and Judgment March 2, 2009. The Ninth Circuit's Memorandum was filed May 10, 2010.

(ii) The Petition for Rehearing En Banc was denied June 29, 2010. The mandate was issued July 7, 2010.

(iii) The Order (by letter) granting an extension of time to file the petition for a writ of certiorari was issued September 14, 2010, and the deadline extended to October 12, 2010.

(iv) This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

STATUTES, REGULATIONS, COURT RULES INVOLVED

Title 29, United States Code, Section 1104(a)(1):

"[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries".

Title 29, United States Code, Section 1133(1) - (2):

Every employee benefit plan shall—

"(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim".

Title 29, Code of Federal Regulations, Section 2520.102-3:

Contents of summary plan description.

...**The summary plan description *must* accurately reflect the contents of the plans** ... The following information ***shall be included*** in the summary plan description of ... employee welfare

benefit plans ...

(j) The plan's requirements respecting eligibility for participation and for benefits.....

* * *

2) For employee welfare benefit plans, it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits....

* * *

(l) For ... welfare benefit plans, a statement clearly **identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction...of any benefits** that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section. ... The foregoing summaries shall be disclosed in accordance with the requirements under 29 C.F.R. § 2520.102-2(b).

Title 29, Code of Federal Regulations, Section 2560-503-1(a):

"... this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits ..."

Title 29, Code of Federal Regulations, Section 2560-503-1(b)(1-3), (b)(5):

"Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing ... notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if –

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate... .

(2) A description of all claims procedures ... and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. ...

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants".

Title 29, Code of Federal Regulations, Section 2560-503-1(c)(2):

"... (2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act".

Title 29, Code of Federal Regulations, Section 2560-503-1(f):

"Timing of notification of benefit determination. (1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time,". ...

Title 29, Code of Federal Regulations, Section 2560-503-1(f)(3):

"Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination ..."

Title 29, Code of Federal Regulations, Section 2560-503-1 (g)(1)(iv)-(v)(a):

"Manner and content of notification of benefit determination. (1) Except as provided in paragraph

(g)(2) of this section, the plan administrator shall provide a claimant with written ... notification of any adverse benefit determination. ... The notification shall set forth, in a manner calculated to be understood by the claimant --

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

...

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request".

Title 29, Code of Federal Regulations, Section 2560-503-1 (h)(4):

"Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section".

Title 29, Code of Federal Regulations, Section 2560-503-1 (h)(2)(iii)-(iv):

"Appeal of adverse benefit determinations.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures – ...

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination".

Title 29, Code of Federal Regulations, Section 2560-503-1(i)(5):

"Timing of notification of benefit determination on review. ...

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan

administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate".

Title 29, Code of Federal Regulations, Section 2560-503-1(j)(2)-(3) and (5)(i):

"Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written ... notification of a plan's benefit determination on review. ... In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section"

(5) In the case of ... a plan providing disability benefits -- (i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar

criterion will be provided free of charge to the claimant upon request";

Title 29, Code of Federal Regulations, Section 2560-503-1(*l*):

"Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim".

Title 29, Code of Federal Regulations, Section 2560-503-1(m)(4) – (5) and (8)(iv):

"Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) ...

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) ...

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information. ...

(iv) In the case of ... a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's

diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination".

STATEMENT OF THE CASE

1. Theresa Noren participated in an ERISA plan administered by Jefferson Pilot Financial Insurance Company, through her employment with CarToys.[2] Noren became disabled in June 2005 and filed for short-term disability benefits. After administrative proceedings, Jefferson denied the claim November 3, 2006. App.34a. The denial letter stated she "may" appeal a second time. November 6, 2006, Noren asked for 180 days from receipt of the complete administrative file to appeal. App. 39a. Jefferson noted this request as a "second appeal". App.42a. In this and at least one other letter, Noren asked whether this was an ERISA plan and also for disclosure of relevant documents, including the basis ("Presley Reid Disability Advisor guidelines") for denying benefits. App.39a. These guidelines formed the basis for denial.[3]

2. Jefferson neither denied nor agreed this was an ERISA plan, and did not provide the requested and required documents. Though Jefferson had initially documented Noren's November 6, 2006 request as a second appeal, no additional material was sent in by Noren.

3. Noren brought suit in the Western District of Washington, and thereafter moved to compel in order to access materials Jefferson was required to disclose but had never provided her.

4. In reply, Jefferson for the first time asserted the affirmative defense of "prudential

---

[2] On approximately April 3, 2006, Jefferson Pilot merged with Lincoln National Corporation of Pennsylvania. The merged company operates now as Lincoln Financial Group.

[3] App.32a, 36a(3-7 days disability for fibromyalgia).

exhaustion," claiming Noren failed to submit facts bringing her claim within the exceptions to exhaustion.

5. The district court concluded that the Plan required two appeals, that Jefferson had no obligation to notify Noren of the two-appeal requirement, and she did not complete a second appeal. The court dismissed with prejudice, App.7a-13a, without considering Noren's Motion to Compel materials Jefferson never provided.

6. Without oral argument, a majority of the Ninth Circuit Court of Appeals panel affirmed, in an unpublished decision dated May 10, 2010 (App.2a-5a). The majority concluded Noren failed to demonstrate any exception to the exhaustion requirement. The majority held Noren waived the argument that under 29 C.F.R. §2560.503-1(*l*), Jefferson's "unreasonable procedures" deemed the remedies to be exhausted.

7. The dissent concluded Noren had preserved the latter argument, and instead the Court should reverse and "remand for the district court to develop the record as to this claim and its application to the ERISA regulations in the first instance"—that is, a triable issue.

8. The petition for rehearing en banc was denied.

9. Initial subject matter jurisdiction was based on 29 U.S.C. §§ 1132(e)(1) and (f), and 28 U.S.C. § 1331, as this matter arose under the Employee Retirement Income Security Act (ERISA), a federal law. The Ninth Circuit had jurisdiction under 28 U.S.C. § 1291.

REASONS FOR ALLOWING THE WRIT

I. PRELIMINARY STATEMENT RE CONFLICTS

The Ninth Circuit in this case decided an important question of federal law on which the circuits conflict: that is, whether a difference between the Summary Plan Description (SPD) and a provision in an ERISA plan violates ERISA's requirement that insurers notify plan participants of all time limits and exhaustion procedures, thus precluding the insurer from asserting the non-jurisdictional affirmative defense of "prudential exhaustion."

In the process of so deciding, the Ninth Circuit's decision conflicts with this Court's holding that non-statutory defenses are not jurisdictional. The rule should be when the SPD and a plan provision conflict on exhaustion of remedies, the insurer's failure to give the claimant mandated notice of the procedures and time limits for exhaustion is fatal to any exhaustion defense. This Court should grant certiorari to resolve the question.

The Ninth Circuit also ignored the critically-important and potentially-fatal result of applying prudential exhaustion to bar a claimant's right to judicial review in an ERISA benefits-denial case.

A court's unfamiliarity with ERISA minimum regulations and misuse of prudential exhaustion improperly relieves insurers of their duties to plan participants. It effectively lowers the standards that plan administrators must meet and allows them to escape their fiduciary duties. That is what happened in this case.

With few appellate cases explaining prudential exhaustion in ERISA actions, a writ of certiorari is necessary to harmonize the variety of Circuit Court holdings and to rule that:

(a) An insurer's failure to give ERISA-required notice of all procedures and time frames in the SPD bars it from asserting the non-statutory, non-jurisdictional defense that the claimant failed to exhaust administrative remedies she never knew about.

(b) Where there is a conflict between the SPD and a plan provision, the version most favorable to the claimant prevails.

II. THE COURT SHOULD ACCEPT CERTIORARI TO HARMONIZE CIRCUIT CONFLICTS OVER THE EFFECT OF ERISA-REQUIRED NOTICE AND DISCREPANCIES BETWEEN THE PLAN AND SPD.

A. Without ERISA-Required Notice, Insurers Cannot Assert Prudential Exhaustion.

The Second Circuit in *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 110 (2d Cir. 2003) harmonized these rules, but other courts have strayed from these principles and issued a chaotic variety of decisions.

Generally, where a plan provision differs from the SPD, circuit courts have conflicted over which should govern as discussed below. Some have held that the SPD controls; others say the opposite or simply ignore the SPD. Still others require detrimental reliance by, or prejudice to, the

claimant.

The specific rule, however, is that, where the insurer violates ERISA-required minimum regulations requiring it to give notice in the SPD of procedures and time frames that are a prerequisite to judicial review, 29 C.F.R. § 2560.503-1(b) (set forth below), the court is not deprived of jurisdiction, but rather, the insurer must prove it gave such notice before it can assert exhaustion as a defense.

ERISA requires that the appeals process be in the SPD to satisfy notice regulations. Minimally, the SPD must ensure claimants know ***all* claims procedures and time limits for appealing adverse benefit determinations.** 29 C.F.R. § 2560.503-1(b):[4]

> **(b) Obligation to establish and maintain reasonable claims procedures.** Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). **The claims procedures for a plan will be deemed to be reasonable *only if* –**
>
> (1) The **claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j)** of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

---

[4] *See also* 29 C.F.R. § 2520.102-3(j)(2); 29 C.F.R. § 2520.102-3(l).

> **(2) A description of *all* claims procedures ... and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 C.F.R. § 2520.102-3[.][5]**

(Emphasis added.)

Judicial review is an integral part of ERISA's appeal procedure for an adverse benefit determination; therefore, the regulations require plan administrators to give adequate notice of the time limits for such review. 29 C.F.R. § 2560.503-1.[6]

Precisely as a result of the insurer's violation of the same regulation at bar, 29 C.F.R. § 2560.503-1(b), in *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 110 (2d Cir. 2003), the Second Circuit ordered judgment entered for the claimant harmed by the insurer's violation:

> ERISA requires employers to distribute SPDs describing the plan's benefits to their employees. 29 U.S.C. §1022(a) & 1024(b). The SPD must be written in a manner calculated to be understood by the average plan participant and must be sufficiently accurate and comprehensive to apprise participants and beneficiaries of their rights and obligations under the plan. *Id.* at §1022(a). Significantly, the SPD must contain the plan's eligibility requirements for benefits

---

[5] Section 2520.102-3 provides at a minimum, that to ensure claimants know, the insurer must include in the SPD ***all* claims procedures** and time limits for appealing adverse benefit determinations. 29 C.F.R. § 2520.102-3(j)(2) and 29 C.F.R. §2520.102-3(l).

[6] *E.g.*, 29 C.F.R. §2560.503-1(a), (b), (f), (g)(1), (h)(4), (j); 29 U.S.C. §1133(1).

> as well as "*the circumstances which may result in disqualification, ineligibility or denial or loss of benefits.*" ***Id.*** **at § 1022(b); see also 29 C.F.R. §2520.102-3(l).**
>
> ERISA further requires that: (1) the SPD's format not mislead or fail to inform participants and beneficiaries about the plan; and (2) any limitations or restrictions of plan benefits must not be minimized, rendered obscure, or otherwise made to appear unimportant. *See* **29 C.F.R. §2520.102-2(b).** Restrictions on benefits need not be disclosed "in close conjunction with the description or summary of benefits provided that adjacent to the benefit description the page on which the restrictions are described is noted." *Id.* ("cross-referencing" requirement); *see also id.* at § 2520.102-2(a) ("the use of clear cross-references [is] usually required" in an SPD).

As should have occurred here, the Second Circuit recognized that the insurer's violation operated to bar the claimant's right to judicial review:

> Under the ERISA statute and the DOL regulations, the denial must notify the claimant of appeal procedures under the plan. *See* 29 U.S.C. §1133 & 29 C.F.R. §2560.503-1. A written notice of denial must be comprehensible and provide the claimant with the information necessary to perfect her claim, including the time limits applicable to administrative review. *Id.* A notice that fails to substantially comply with these requirements does not trigger a time bar contained within the plan. *See White v. Jacobs*

Eng'g Group Long Term Disability Benefit Plan, 896 F.2d 344, 350 (9th Cir. 1990).

Kodak's notice was inadequate for two reasons.

First, Kodak's initial denial letter does not expressly say that Mrs. Burke had ninety days to appeal. ... Based on the denial letter's exclusive reference to spousal eligibility, Mrs. Burke's focus in turning to the handbook would justifiably have been on her eligibility, not on the time limit for appeals. *See Ross v. Diversified Benefit Plans, Inc.*, 881 F.Supp. 331, 335 (N.D. Ill. 1995)(notice insufficient where denial letter "did not mention the Plan's appeal procedure or specifically refer the claimant to the Plan book for information about the appeal procedure").

...

Secondly, even if Kodak's denial letter had cross-referenced the time limitation's provision in the handbook, the language requiring appeal within ninety days is opaque:

...

The Kodak handbook's use of the word "should" is grossly uninformative. *Cf. Harris County Hosp. Dist. v. Shalala*, 863 F. Supp. 404, 410 (S.D.Tex. 1994), *aff'd*, 64 F.3d 220 (5th Cir. 1995) ("Should," in administrative manual, "is mandatory only when used as the past tense of shall. Otherwise, should is precatory.").... It is not necessary to hold that "should" can never be construed as mandatory. *See Doe v. Hampton*, 184 U.S. App. D.C. 373, 566 F.2d 265, 281 (D.C. Cir. 1977)(use of "should" rather than "shall" or

> "must" is not automatically determinative of whether regulation is mandatory or merely precatory). In this case, however, we decline to equate "should" with "shall" or "must."[7]
>
> Here, Kodak could easily have used unambiguous mandatory language. ...
>
> ... [W]e conclude that Mrs. Burke was denied the opportunity for the full and fair review contemplated by 29 U.S.C. §1133 and the DOL regulations.

Burke, at 107-09.

The Ninth Circuit has addressed the interaction of prudential exhaustion and ERISA-required notice in terms of excusing the defense of prudential exhaustion, but this is not the direct approach that courts should take. In *Dishman v. UNUM Life Ins. Co. of Am.*, 269 F.3d 974, 984-85 (9th Cir. 2001), the court held that the failure to give adequate notice **excuses** a claimant from exhausting administrative remedies. In that case, the insurer at first paid benefits but after surreptitiously investigating the claimant, a claims representative called to tell Dishman she was denying his claim, later retreating to say she was "suspending" his benefits until he provided certain information. There was no policy provision or claims procedure regarding "suspension." Dishman requested a copy of the procedures. The insurer ignored the first request, and Dishman asked again. The insurer responded that it did not have a claims procedure

---

[7] This is precisely the same analysis as should have been applied to the insurer's use of "may" with regard to what it later contended was a "required" second appeal. No one would understand "may" to mean "must." App.37a. Furthermore nothing prevented Jefferson from quoting the specific language in the plan to avoid any ambiguity. *Id.*

regarding suspension and termination of benefits. Though this case is substantially similar to *Dishman*, and though in the courts below, Noren argued the issues of notice and the one-appeal disclosure in the SPD, the Ninth Circuit and District Court ignored both.

The Ninth Circuit has also addressed the failure to give notice of a contractually-required arbitration procedure before the claimant could seek judicial review, which prevents the plan from arguing exhaustion. *Chappel v. Laboratory Corp. of America*, 232 F.3d 719, 726-27 (9th Cir. 2000); *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1033 (9th Cir. 2006).[8] *See also Solien v. Raytheon Long Term Disability Plan # 590*, 2008 U.S. Dist. LEXIS 43194 (D.Ariz. 2008)(applying notice requirements to contractual statute of limitations).

In *Chuck*, the court confirmed the critical nature of notice of a time bar:

> It is indisputable that the clarity and apparent finality of a benefits denial are easily affected by whether the plan discloses its justifications for the denial and by whether there has been a reasonable opportunity for full and fair review of that denial.... A] plan's compliance with §1133 serves crucial information-providing and signaling functions that lend certainty to a claimant's understanding whether a given denial is final or appealable. A plan's failure to comply with §1133, conversely, deprives claimants of a

[8] *See also LaMantia v. Voluntary Plan Administrators, Inc.*, 401 F.3d 1114, 1119-20 (9th Cir. 2005); *White v. Jacobs Eng'g Group Long Term Disability Ben. Plan*, 896 F.2d 344, 350-52 (9th Cir. 1990).

> congressionally mandated means of knowing the proper import of, and response to, a benefits denial.
>
> . . .
>
> ... [A]dequacy of notice is "important to [claimants'] to obtain full and fair reviews of their claims," and the statute and regulations "reveal a purpose to aid claimants in avoiding the obstacles a plan may place in their paths to the appeals board." ... ERISA likewise reveals a purpose of removing obstacles in claimants' paths to the courts. ... 29 U.S.C. § 1001(b). In keeping with Congress' goal of providing "ready access to the Federal courts," we must remain mindful that "ERISA is remedial legislation which should be liberally construed in favor of protecting participants in employee benefit plans."

Id. at 1033-35.

The Ninth Circuit and other circuits have not reconciled the violation of 29 C.F.R. §2560.503-1(b) with the various holdings regarding a conflict between an SPD and a policy provision, or ERISA's notice requirements generally.

B. Conflicts Between SPD and Plan.

If an SPD and a policy covered by ERISA conflict, the more favorable document controls. *Bergt v. Retirement Plan for Pilots Employed by Mark Air, Inc.*, 293 F.3d 1139, 1145 (9th Cir. 2002). The Ninth Circuit in *Bergt* joined the Second, Fifth, Sixth, Tenth, and Eleventh Circuits: *Heidgerd v. Olin Corp.*, 906 F.2d 903, 907-08 (2d Cir. 1990); *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 982 (5th Cir.

1991); *Edwards v. State Farm Mut Auto. Ins. Co.*, 851 F.2d 134, 136-37 (6th Cir. 1988); *Chiles v. Ceridian*, 95 F.3d 1505, 1511 (10th Cir. 1996); *Alday v. Container Corp. of America*, 906 F.2d 660, 665-66 (11th Cir. 1990); *McKnight v. Southern Life & Health Ins. Co.*, 758 F.2d 1566, 1570-71 (11th Cir. 1985). In reaching this holding, the *Bergt* court quoted *Hansen*:

> Any burden of uncertainty created by careless or inaccurate drafting of the summary must be placed on those who do the drafting, and who are most able to bear that burden, and not on the individual employee, who is powerless to affect the drafting of the summary or the policy and ill equipped to bear the financial hardship that might result from a misleading or confusing document. Accuracy is not a lot to ask.

Bergt, 293 F.3d at 1146 (quoting *Hansen*, 940 F.2d at 982).

The SPD, an integral part of the plan,[9] is an employee's primary source of information regarding the plan on which the employee is entitled to rely on its content. *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 110 (2d Cir. 2003). *Bergt* added: "the law should provide as strong an incentive as possible for employers to write the SPDs so that they are

---

[9] *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. Skinner Engine Co.*, 188 F.3d 130, 135 n.3 (3d Cir. 1999)(citing *Jensen v. SIPCO, Inc.*, 38 F.3d 945, 949 (8th Cir. 1994); *Alday*, 906 F.2d at 665 (11th Cir. 1990)); *Bergt*, 293 F.3d at 1143); *Chiles*, 95 F.3d at 1511 & 1515 (10th Cir. 1996). *See also Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S.Ct. 865, 877 (2009).

consistent with the ERISA plan master documents, a relatively simple task." *Bergt,* 293 F.3d at 1145-46.

Bergt applied the well-established rule that an ambiguity between terms of a contract (the SPD and the plan), must be construed against the drafter. *Id.* at 1143, 1146. *See also, e.g., Banuelos v. Constr. Laborers' Trust Funds*, 382 F.3d 897, 904 (9th Cir. 2004)("Courts will generally bind ERISA defendants to the more employee **favorable of two documents -- even if one is erroneous**"); *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1321 (9th Cir. 1995)(pre-*Bergt;* where an SPD fails to explain circumstances that can lead to a denial of benefits, "and differs materially from the terms of the plan, the SPD is controlling"), *overruled on other grounds by Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (2006); *Arnold v. Arrow Transp. Co.*, 926 F.2d 782, 785 n.3 (9th Cir. 1991)(an SPD can expand benefits beyond those in a master plan document).[10]

The circuits split over whether a conflict exists when an SPD is silent about a matter addressed in the policy. The Second Circuit in *Burke* held that silence in an SPD regarding an issue described in a related insurance policy creates a conflict between the two documents. *Burke,* 336 F.3d at 111 (SPD omitted affidavit requirement listed in policy, so SPD controlled). Here, the SPD's silence regarding two appeals creates a conflict with the plan.

Other circuits have held no conflict exists. *See, e.g., Koons v. Aventis Pharms., Inc.*, 367 F.3d 768,

---

[10] *E.g.*, in *Vaught v. Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008), the SPD stated all denial letters would detail the review requirements. Unlike here, they did. Consistent with ERISA, the claimant had notice of time limits and provisions requiring exhausting administrative remedies.

775 (8th Cir. 2004); *Mers v. Marriott Int'l Group Acc. Death and Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998). The Ninth Circuit has not addressed the issue of silence in an SPD.

Here, the Ninth Circuit overlooked the law and this Court's directives. The SPD describes only one appeal, not the plan's a two-appeal requirement. *Compare* App.25a-26a (SPD--one appeal) *with* App.27a (Plan--two appeals); App.28a-29a ("Review Procedure"--nothing about two appeals; "Claims Subject to ERISA" requires two appeals **if** the plan is an ERISA plan).[11] The denial letter (Dec. 12, 2005), App.32a-33a, only vaguely mentions "the policy" and "terms of the contract", "policy language" and "ERISA regulations" as guiding the insurer's handling of each "unique" claim.

Whether this is construed as a conflict or silence on the exhaustion defense, the insurer's omission of the procedures and time frames that it says Noren failed to exhaust was fatal to its defense. What the insurer labeled as jurisdictional was never that. It was the insurer's obligation to give notice to the claimant before she could conceivably fail to exhaust undisclosed procedures.

Courts ignore this Court's clarification that a non-statutory defense is not jurisdictional, but instead an affirmative defense. The Second Circuit rule is correct: when an SPD is silent on a matter that affects a claimant's right to judicial review, but conflicts with the related policy, the plan has failed

---

[11] The insurer never told Noren her plan was an ERISA plan, despite repeated requests from her lawyer. App.30a-31a (Nov. 15, 2005); App.39a-41a (Nov. 6, 2006).

to comply with ERISA's notice mandate of critical procedures and time limits.

The circuits also split over whether detrimental reliance or prejudice is required in deficient SPD cases. The Second Circuit requires prejudice:

> The consequences of an inaccurate SPD must be placed on the employer. The individual employee is powerless to affect the drafting and less equipped to absorb the financial hardship of the employer's errors. ... The employer, however, receives a substantial benefit in return: a defense against certain state law claims....*see also* 29 U.S.C. §1144(a) (ERISA provisions "supersede any and all State laws insofar as they may . . . relate to any employee benefit plan")....
>
> ...[W]e require, for a showing of prejudice, that a plan participant or beneficiary was likely to have been harmed as a result of a deficient SPD. ...

Burke, 336 F.3d at 113.

The Third, Seventh and Eleventh Circuits require detrimental reliance. *See Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1319 n.8 (3rd Cir. 1991); *Andersen v. Chrysler Corp.*, 99 F.3d 846, 859 (7th Cir. 1996); *Branch v. G. Bernd Co.*, 955 F.2d 1574, 1578-79 (11th Cir. 1992). They generally require that claimant read the SPD and but for the inaccurate description would have acted differently. *See, e.g., Collins v. Am. Cast Iron Pipe Co.*, 105 F.3d 1368, 1371 (11th Cir. 1997).

The First, Fourth, Eighth and Tenth Circuits allow recovery upon a showing of either reliance or prejudice. *See Govoni v. Bricklayers, Masons &*

Plasterers Int'l. Union of Am., Local No. 5 Pension Fund, 732 F.2d 250, 252 (1st Cir. 1984); *Aiken v. Policy Mgmt. Sys. Corp.*, 13 F.3d 138, 141-42 (4th Cir. 1993)(per curiam); *Palmisano v. Allina Health Sys., Inc.*, 190 F.3d 881, 887-88 (8th Cir. 1999); *Chiles*, 95 F.3d at 1519.

The Fifth and Sixth Circuits in dicta would require neither reliance nor prejudice. *See Hansen*, 940 F.2d at 983; *Edwards*, 851 F.2d at 137.

The Ninth Circuit has not addressed the issue.

The circuits' confusion[12] demands this Court's

---

[12] As one trial judge cynically described the courts' handling of ERISA cases:

> This court knows from experience that, under ERISA, trial courts, despite never having seen a live witness, routinely make, or purport to make, credibility determinations to resolve disputes between irreconcilable unsworn written testimony. It would, of course, constitute a *Rule 11* violation for an ERISA beneficiary to file an action seeking to recover benefits without having any evidentiary support whatsoever for his claim. On the other hand, a plan administrator can always be counted on to say that it relied, in reaching its decision, upon evidence that predictably contradicts the evidence offered by the beneficiary. Otherwise, there would be no dispute, and no federal court involvement. *Rule 56* simply does not fit an ERISA case. This is why the parties in the above-entitled case appropriately adopt the innovative "motion for judgment as a matter of law", arrived at by adapting procedures from administrative law. Even Dr. Watson, without Sherlock's help, could deduce from this procedural dilemma either that a new procedural rule should be created for ERISA cases, or that ERISA should be applied as it was written by Congress.

Blankenship v. Metropolitan Life Ins. Co., 686 F.Supp.2d 1227, 1232-33 (N.D.Alabama 2009).

acceptance of certiorari because ERISA requires all procedures and time frames to be in the SPD; the insurer's violation of notice requirements, or any silence or conflict on the matter, precludes it from asserting prudential exhaustion as an affirmative or jurisdictional defense.

Whether detrimental reliance or prejudice is required, Noren's lost right to seek judicial review severely prejudiced her. Had the insurer identified the ERISA plan, Noren still had the right to rely on the SPD's description of only one review.

Certiorari is needed to enunciate that prudential exhaustion cannot be asserted if an insurer failed to unambiguously notify a claimant of its administrative review procedures which bar the right to judicial review in a manner calculated to be easily understood.[13] As addressed below, failure to notify the claimant of internal review procedures is an unreasonable procedure, which deems the administrative remedies to be exhausted. 29 C.F.R. §2560.503-1(*l*).

Any other holding would relieve insurers of the duty to notify a plan participant of the time limits and requirements necessary for filing an action and obtaining court review. Insurers could avoid their duty under ERISA by omitting appeal or exhaustion requirements in their SPD. This Court cannot approve this practice.

---

[13] *See, e.g., Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008); 29 U.SC. 1104.

III. THE NOREN DECISION CONFLICTS WITH THIS COURT'S HOLDING THAT NON-STATUTORY DEFENSES ARE NOT JURISDICTIONAL.

A. The Ninth Circuit Ignored, And This Court Should Settle, The Rule That Prudential Exhaustion Is A Non-Jurisdictional Affirmative Defense.

By allowing the insurer to assert the non-jurisdictional defense of prudential exhaustion in Reply, and then misapplying that defense as depriving the court of jurisdiction, the Ninth Circuit entered a decision in conflict with this Court's holding in *Bowles v. Russell*, 551 U.S. 205 (2007); *Arbaugh v. Y&H Corp.*, 546 U.S. 500 (2006); *Eberhart v. United States*, 546 U.S. 12 (2005)(per curiam); and *Kontrick v. Ryan*, 540 U.S. 443 (2004).

In *Bowles*, the Court clarified that non-statutory claim-processing rules are not properly labeled "jurisdictional." True "jurisdictional" limitations are set by the Constitution and by Congress, not by rules of procedure or judge-made doctrine. *See Kontrick*, 540 U.S. at 452 ("Only Congress may determine a lower federal court's subject-matter jurisdiction."); *see also Bowles*, 127 S. Ct. at 2364-65 & n.3 (same). Non-statutory rules, "even if unalterable on a party's application, can nonetheless be forfeited if the party asserting the rule waits too long to raise the point." *See Kontrick*, 540 U.S. at 456.

Bowles held that its own past decisions had sometimes mislabeled non-statutory rules as

"jurisdictional." The Court described these casual invocations of the term as "drive-by jurisdictional rulings that should be accorded no precedential effect on the question whether the federal court had authority to adjudicate the claim in suit." *Arbaugh*, 126 S. Ct. at 1242-43 (quotation marks omitted).

The Ninth Circuit here violated this rule by accepting prudential exhaustion (raised only in Reply, no less) as a jurisdictional argument justifying dismissal. This is despite the fact that the Ninth Circuit has followed *Bowles:*

> *Bowles v. Russell*, 551 U.S. 205 ... (2007), clarified that court-promulgated rules are not jurisdictional.... Because *Bowles* supercedes our prior decisions, we must clarify that the exhaustion requirement set forth in *Amato* is not a jurisdictional requirement. *See Miller v. Gammie*, 335 F.3d 889, 893 (9th Cir. 2003) (en banc).

Vaught v. Healthcare Corp. Health Plan, 546 F.3d 620, 627 (9th Cir. 2008).

> [A]s a judicially-crafted doctrine, exhaustion places no limits on a court's adjudicatory power.... Unlike a rigid jurisdictional rule, prudential exhaustion provides flexible exceptions for "waiver, estoppel, tolling or futility." ... **In addition to being judge-made, the doctrine's futility exception involves a discretionary balancing of interests. Judicial prudence, not power, governs its application in a given case.**

Metro. Life Ins. Co. v. Price, 501 F.3d 271, 279 (3d Cir. 2007)(emphasis added). *See also Pease v. Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 445

(2d Cir. 2006); *Chailland v. Brown & Root, Inc.*, 45 F.3d 947, 950 n.6 (5th Cir. 1995).

B. The Court Should Guide Lower Courts Regarding *Bowles'* Distinction Between A Jurisdictional Bar And A Non-statutory Affirmative Defense, So That Exceptions To Prudential Exhaustion Are Accurate And Consistent.

1. Exceptions To Prudential Exhaustion.

Although, violation of the requirement to provide notice of all procedures and time frames in the SPD prevents prudential exhaustion, exceptions also overcome the affirmative defense. Exhaustion may provide an affirmative defense unless exhaustion was futile, or the plan's procedures were unreasonable (now codified in a regulation, 29 C.F.R. § 2560-503.1(*l*)), or the remedy was inadequate.

Here, because Jefferson moved to dismiss on jurisdictional grounds, raising "prudential exhaustion" as a new argument in their Reply, the courts perceived the **non-statutory** exhaustion defense as jurisdictional. Taking exhaustion as a jurisdictional bar reduced the courts' belief in its authority to excuse any failure to exhaust administrative remedies.

Naturally, courts hesitate to excuse noncompliance with a **statutory** exhaustion requirement, which **is jurisdictional.** Consequently, the circuits differ over the courts' power to excuse such noncompliance:

> While there is conflicting legal authority on this point, this Court concludes

> that it does have the power to excuse noncompliance with the exhaustion requirement of 7 U.S.C. §6912. *See Bowen v. City of New York*, 476 U.S. 467, 482-83, 106 S.Ct. 2022, 90 L.Ed. 2d 462 (1986); *Dawson Farms, LLC v. Farm Serv. Agency*, 504 F.3d 592, 597 (5th Cir. 2007); *Ace Prop. & Cas. Ins. Co. v. Fed. Crop. Ins. Corp.*, 440 F.3d 992, 1000 (8th Cir. 2006); *McBride Cotton & Cattle Corp. v. Veneman*, 290 F.3d 973, 980 (9th Cir. 2002); ***Dishman v. UNUM Life Ins. Co. of America*, 269 F.3d 974, 984-85 (9th Cir. 2001);** *Northwest Tissue Ctr. v. Shalala*, 1 F.3d 522, 530-31 (7th Cir. 1993); *The Lands Council v. Vaught*, 198 F.Supp.2d 1211, 1241 (E.D. Wash. 2002). ***But see*** *Bastek v. Fed. Crop Ins. Corp.*, 145 F.3d 90, 94-95 (2nd Cir. 1998).

Sierra Club v. United States Forest Serv., 535 F.Supp.2d 1268, 1311 (N.D.Ga. 2008)(emphasis added; citing *Dishman*, which involves non-jurisdictional prudential exhaustion).

But courts can easily excuse non-compliance with the judicially-created, nonstatutory defense, prudential exhaustion. The Third Circuit stated in *Metropolitan Life Insurance Co. v. Price*, 501 F.3d 271, 279 (3rd Cir. 2007), "In addition to being judge-made, the doctrine's futility exception involves a discretionary balancing of interests. Judicial prudence, not power, governs its application in a given case."

Courts have only infrequently told a claimant what would be sufficient to satisfy those exceptions. As discussed above, in *Dishman*, 269 F.3d at 984-85, the court excused the claimant from exhausting his

administrative remedies because, as here, the plan "gave him inadequate notice of both the denial of his claim and the available appeals procedure." *Id.* at 984.

In *Vaught v. Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008), the Ninth Circuit concluded that the record showed the claimant **did** exhaust the administrative remedies. Therefore, *Vaught* did not reach the question whether the claimant demonstrated an exception. *Id.* at 629.

The majority here never actually considered whether, or explained why or why not, Noren exhausted her administrative remedies, but proceeded directly to the exceptions. The record showed Noren exhausted her remedies and satisfied the exceptions for futility and unreasonable procedures.[14]

2. Deemed Exhausted Regulation.

Under ERISA's "deemed exhausted" regulation, 29 C.F.R. § 2560.503-1(*l*)(2002), the failure to notify and other violations constitute an unreasonable claims procedure, violation of which deems the appeal procedures to be exhausted. The

---

[14] Unlike in *Vaught v. Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008), the denial letter here lacks notice of: (1) review requirements (stating Noren "may" appeal "if" she had an ERISA plan) and (2) the critical consequence of losing the statutory right to seek judicial review without a second appeal. Viewing the evidence and inferences in Noren's favor, she filed two appeals. This includes the insurer's own worksheet recognizing the "second appeal." App.42a. Viewing that against the insurer and in Noren's favor required denial of summary judgment as to exhaustion, a question ambiguous even to the insurer.

Court should breathe life into this relatively new regulation, which is intended to remedy insurer's practically routine flaunting of ERISA.

The "deemed exhausted" exception to prudential exhaustion, 29 C.F.R. §2560.503-1(*l*), has been addressed primarily by district courts, and rarely by appellate courts. Most recently, the Fifth Circuit applied § 2560-503.1(*l*) to hold although the claimant had not exhausted his remedies, the insurer's failure to notify him it had denied his claim allowed the court to deem the remedies exhausted:

> [W]hen the administrator fails to "follow claims procedures consistent with the [regulatory] requirements," including providing adequate notice that it has denied the claim, "a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any remedies under section 502(a) of [ERISA] on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." *See* 29 C.F.R. §2560.503-1(*l*).

Baptist Mem. Hosp. - Desoto, Inc. v. Crain Auto., Inc., 2010 U.S. App. LEXIS 17518, at *10 (5th Cir. Aug. 19, 2010). Certainly, where the insurer has blatantly omitted an exhaustion provision (the two-appeal provision) in the SPD, it has by definition followed unreasonable procedures and violated the minimum requirement in § 2560.503-1(b)(2), meaning the claimant is deemed to have exhausted her remedies.

In *Kegel v. Brown & Williamson Tobacco Corp.*, 2009 U.S. Dist. LEXIS 88783 (D. Nev. 2009),

the plan violated § 2560.503-1(g) when the denial letter failed to provide the specific plan provision, review procedures, and time limits. Under § 2560.503(1)(*l*) the claimant's remedies were deemed exhausted.

In *Asgaard v. Pension Comm.*, 2006 U.S. Dist. LEXIS 74679 (W.D.Mich. 2006), the defendants, claiming they had "tolled" ERISA deadlines, never provided plaintiffs with relevant documents they requested. The court rejected the exhaustion defense:

> ERISA regulations make clear that claimants are entitled to such documents. 29 C.F.R. §2560.503-1(h)(2)(iii). ...Taken to its extreme, the defendants' argument would allow an ERISA plan administrator to avoid judicial review indefinitely by merely refusing to supply requested documents or refusing to decide a claim on review. This does not comport with the requirement of a 'full and fair review' of claim determinations under ERISA. 29 U.S.C. §1133.... [D]efendants have failed to abide by the specific review timelines provided in 29 C.F.R. §2560.503-1(i).

Id. at 20-21, 25.[15]

---

[15] *See also, e.g., Brogan v. Hartford Life Ins. Co.*, 2009 U.S. Dist. LEXIS 85101, 12-13 (S.D.Ohio 2009); *Linder v. BYK Chemie USA, Inc.*, 313 F.Supp. 2d 88 (D.Conn. 2004) (regulation "is unequivocal that any failure to adhere to a proper claims procedure is sufficient to deem administrative remedies exhausted"); *Fleming v. Kemper Nat'l Servs.*, 2004 U.S. Dist. LEXIS 28381 (N.D.Cal. 2004) (denying summary judgment); *Urso v. Prudential Ins. Co. of Am.*, 2004 U.S. Dist. LEXIS 23930, 2004 WL 3355265 (D.N.H. 2004)(same; violation of 29 C.F.R. §2560.503-1(i)); *Urso v. Prudential Ins. Co. of Am.*, 2004 DNH 167 (D.N.H. 2004)("The court is not

The Ninth Circuit and the Second Circuit have recognized, but not applied 29 CFR § 2560.503-1(*l*) to deem remedies exhausted as a result of a plan's unreasonable procedures. In *Vaught v. Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008), the Court recognized 29 CFR § 2560.503-1(*l*) as an exception to exhaustion, but did not rule on that basis because the claimant had exhausted his remedies. The Second Circuit, in *Eastman Kodak Co. v. STWB, Inc.*, 452 F.3d 215, 223 (2d Cir. 2006), cited 29 CFR § 2560.503-1(*l*) to reject the exhaustion defense when the asserted review procedure came into effect **after** the lawsuit. Certiorari is justified here to provide guidance as to 29 CFR § 2560.503-1(*l*)'s effect.[16]

---

persuaded that any policy favoring exhaustion would override the operation of the regulatory framework in this case"); *Barboza v. Cal. Ass'n of Prof'l Firefighters*, 2009 U.S. Dist. LEXIS 52848 (E.D.Cal. 2009)(503-1(*l*) not available under the facts); *Tindell v. Tree of Life, Inc.*, 672 F. Supp.2d 1300, 1312 (M.D. Fla. 2009)(same).

[16] The record demonstrates unreasonable procedures by, *inter alia*, inadequate notice in that Jefferson did not: (1) tell Noren she had an ERISA plan, triggering a two-appeal requirement, despite her requests for clarification; (2) disclose policy provisions regarding review in any denial letter; (3) resolve the conflict created by the SPD, providing for one appeal; (4) clarify she **must** (instead stating she "**may**") appeal a second time; (5) notify her that failure to appeal twice would foreclose judicial review. The insurer violated 29 C.F.R. §2560.503-1(f), (g)(1)(iv)-(v), (h)(2)(iii)-(iv), (i)(5), (j)(5)(i), (*l*), (m)(8); 29 U.S.C. §1133(1). *See also* Dissent. App.6a.

3. Futility.

This Court should clarify the courts' authority to enforce the futility exception. Here, the insurer's unreasonable procedures made it futile for Noren to proceed any further after denial of the one review she believed the plan required.[17] Noren raised factual questions by showing that since the insurer did not, despite her repeated requests, provide her with the guidelines they relied on to deny her benefits, or what additional information they desired, another appeal would be fruitless. *See*

---

[17] The majority and dissent differed as to whether Noren had waived the claim that the insurer's violations of ERISA regulations excused her from exhaustion. App.2a-6a. As the dissent concluded, Noren cited violations of 29 C.F.R. § 2560.503-1(g)(1)(v)(A), (h)(2)(iii)-(iv), (i)(5), (j)(5)(i), (l), (m)(8), and then stated: "Jefferson Pilot's procedural failures have prevented claimant from understanding what the failures were in Plaintiff's claim. Without knowing the shortcomings of the material submitted on appeal, it was useless to submit anything further, if indeed there was even anything further to submit. Noren has therefore preserved her claim that Jefferson Pilot's ERISA violations prevented her administrative exhaustion." In *Vaught v. Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008), the Court held that waiver does not apply in ERISA actions: "No ERISA statute precludes courts from hearing objections not previously raised to the Plan, nor does any ERISA statute or regulation require claimants to identify all issues they wish to have considered on appeal. ... [I]ssue exhaustion is not applicable in the ERISA context." *Id.* at 630-31. The claimant's "decision to raise a new issue before the district court did not retroactively erase his prior effective exhaustion of administrative remedies." *Id.* at 633. In *Eastman Kodak*, the Second Circuit rejected the waiver argument because "appeals courts may entertain additional support that a party provides for a proposition presented below." *Id.* at 221.

Parlanti v. MGM Mirage, 2007 U.S. Dist. LEXIS 20003, at *14-15 (D. Nev. 2007)(claimant alleged, beyond bare assertions, that defendants said there was no way to exhaust remedies and his only recourse was to sue).

The Ninth Circuit ignored futility for Noren to submit further information or a second appeal because the insurer never provided Noren with the linchpin of their denial--the Presley Reid Disability Adviser disability guidelines.App.32a-39a.

4. The Burden Is On the Insurer, Not The Claimant, To Prove The Exhaustion Defense.

Because prudential exhaustion is an affirmative defense, the burden is on the insurer to demonstrate that the claimant failed to exhaust her administrative remedies under the plan. *Metropolitan Life Insurance Co. v. Price*, 501 F.3d 280 (3rd Cir. 2007)("non-jurisdictional affirmative defense"; **insurer** failed to exhaust remedies); *Karpiel v. Ogg, Cordes, Murpy, & Ignelzi, LLP*, 297 Fed. Appx. 192, 194 (3d Cir. 2008); *Pease v. Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 445 (2d Cir. 2006). The Ninth Circuit reversed the true burden of proof from the insurer to the claimant. The *Noren* decision requires the claimant to prove she exhausted her administrative remedies in order to invoke the court's subject matter jurisdiction, when under the law, the insurer must show they clearly notified the claimant of the review procedures and the effect of not exhausting them.

The decision improperly views the law and the facts in favor of the insurer and against the claimant.

IV. THE *NOREN* DECISION CONFLICTS WITH THIS COURT'S HOLDING THAT ERISA IMPOSES ON INSURERS A HIGHER-THAN-MARKETPLACE FIDUCIARY DUTY TOWARD PLAN PARTICIPANTS.

Allowing courts to apply prudential exhaustion as a jurisdictional bar clashes directly with this Court's emphatic enforcement in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008), of ERISA's higher-than-market fiduciary duty owed by insurers toward plan participants. This case presents the opportunity for this Court to harmonize judge-made prudential exhaustion with ERISA's stringent high standard of fiduciary duty and thorough minimum requirements.

Glenn requires insurers to:

(a) Adhere to "higher-than-marketplace quality standards";

(b) Meet a "special standard of care ..., namely, that the administrator "discharge [its] duties" in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries" of the plan, § 1104(a)(1)";

(c) Comply with the important ERISA minimum standards for "accurate claims processing by insisting that administrators 'provide a "full and fair review" of claim denials,' " ... (quoting § 1133(2));"

(d) Follow ERISA's mandate to supplement "marketplace and regulatory controls with judicial review of individual claim denials, *see* § 1132(a)(1)(B)." *Id.*, 128 S. Ct. at 2350. *See also* 29 C.F.R.§2560-503.1(a) (minimum procedural

standards including explicit procedures for giving notice, reporting, and claims processing); 29 U.S.C. § 1021(a)(disclosure to all plan participants); 29 U.S.C. § 1021(b)(reporting requirements); *id.* 29 U.S.C. § 1133 (claims procedures); 29 C.F.R. § 2560.503-1 (implementing the code).

Congressional policy in ERISA to "protect ... the interests of participants in employee benefit plans and their beneficiaries", 29 U.S.C. §1001(b), trumps any "policy"[18] behind prudential exhaustion. Contrary to *Glenn* and ERISA's explicit language, the majority's application of the exhaustion defense seriously prejudices participants. It allows insurers to avoid providing clear notice in denial letters, the only place where such notice has any real force. It permits insurers to conceal and confuse review procedures, as they did here, and then blame claimants for failing to take steps that the insurer did not clearly and adequately disclose to them.

This Court recently stated that "ERISA 'induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred'". *Conkright v. Frommert,* 130 S. Ct. 1640, 176 L. Ed. 2d 469, 478 (2010).

This Court should grant certiorari to establish a uniform rule as outlined in this petition.

---

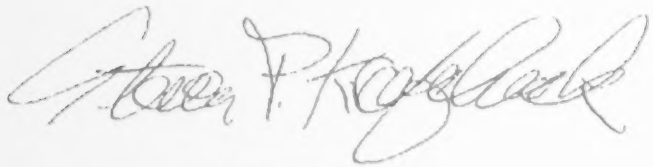
[18] *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980), *overruled in part in Bowles v. Russell*, 551 U.S. 205 (2007).

V. CONCLUSION

Without a comprehensive decision from this Court on prudential exhaustion in ERISA cases and the effect of inadequate notice or unreasonable claims procedures to bar judicial review, insurers will continue to violate ERISA law and regulations, flaunt their fiduciary duties, and preclude participants from their rightful benefits or at least their day in court.

The lower courts have failed to synthesize *Glenn* with the ERISA statutes and minimum regulations or issue uniform decisions. Allowing prudential exhaustion, contrary to ERISA requirements, to deprive courts of jurisdiction reduces ERISA's promises to hollow words.

Respectfully submitted,



Steven P. Krafchick,
Counsel of Record
Carla Tachau Lawrence,
Pamela S. Van Swearingen
Attorneys for Petitioner